Dr. Porterfield

4

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

07293

CERTIFICATE OF DEATH ★ Reg. Dist. No. 303

1. PLACE OF DEATH:
County Washington
City or town Big Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years
Hospital, institution, or street address where death occurred:
Big Pool Road
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Big Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No. Big Pool Road
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME David Hammett Ankeney

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Elizabeth H.
6.(c) If alive, give age 36 years
7. Birth date of deceased (mo., day, yr.) January 18 1907

8. AGE: Years	Months	Days	If less than one day
38	5	26	....hrs. ....min.

9. Birthplace Clear Springs Wash. Co. Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business -

FATHER
12. Name Isaac Ankeney
13. Birthplace Clear Springs

MOTHER
14. Maiden name Maria Flora
15. Birthplace Clears Springs Md.

16. Informant Mrs. David H. Ankeney
Address Big Springs Md.

17. Burial Date thereof 7/19/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Clear Springs Md
18. Funeral director Andrew K. Coffman
Address Hagerstown Md.

July 17 1945 Joseph W. Murray
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH July 16 1945 at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to July 16 1945
and that I last saw h... alive on July 16 1945

	DURATION
Immediate cause of death Coronary occlusion	7/16/45
Due to Subacute Sinusitis	11 10/45
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. H. Porterfield M.D.
M. D. or other
Address 136 W Washington Date signed 7/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

13

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07294

Reg. Dist. No. 30 2

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 837 West Washington Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George L. Ardinger

3.(b) Social Security Number 705-10-6582

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Alta C. Ardinger

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) February 27, 1882

8. AGE:	Years	Months	Days	If less than one day
	63	4	6	...hrs. ...min.

9. Birthplace Marlowe, West Virginia
(Town, county, and state)

10. Usual occupation Boilermaker

11. Industry or business W.M.Railroad

FATHER
12. Name Charles A. Ardinger
13. Birthplace Williamsport, Maryland

MOTHER
14. Maiden name Eliza Lemen
15. Birthplace Williamsport, Maryland

16. Informant Mrs. George L. Ardinger
Address Hagerstown, Maryland

17. Burial Date thereof 7-6-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. July 5, 1945 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1945 at 8:57P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 3 1945 and that I last saw h[illegible] alive on July 3 1945.

	DURATION
Immediate cause of death	
Acute coronary	
Due to	
[illegible]	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE J. Walter Saumenig M.D. M. D. or other

Address Hagerstown Md. Date signed 7/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Layman.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md.)

CERTIFICATE OF DEATH

07295

Reg. Dist. No. 303

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown Route 2 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, Institution, or street address where death occurred: Gateway Nursing Home

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegheny

City or town: Cumberland. (If outside city or town limits, write RURAL and give nearest town)

Street No. 16 Arch Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Emma M. Baker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John A. Baker

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): November 14, 1875

8. AGE: Years	Months	Days	If less than one day
69	8	4	hrs. min.

9. Birthplace: Hagerstown, Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Samuel H. Switzer

FATHER — 13. Birthplace: Washington County Md.

MOTHER — 14. Maiden name: Mary J. Lawrence

MOTHER — 15. Birthplace: Littlestown, Pa.

16. Informant: Mrs. Mary C. Wolfe

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-21-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. July 21, 1945 (Date rec'd by registrar) Lena M. Zeller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18, 1945 19... at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1945 19... to July 18 19 45

and that I last saw h... er alive on July 16, 19 45

Immediate cause of death	DURATION
Acute pulmonary edema	30 min.
Due to: Chronic congestive myocardial failure	3 yrs.
Due to:	
Other conditions: Chronic endocarditis	Indef.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D. D. Schneider M. D. or other

Address: 148 W. Washington St. Date signed: 7/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-2)

CERTIFICATE OF DEATH

07296

Reg. Dist. No. 302

20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

(If not corporate within corporate limits) County: Washington

City or town: Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: Washington County Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 East Antietam Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William E. Beachley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ina Beachley

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): August 15, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	23	..... hrs. ..... min.

9. Birthplace: Funkstown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Dentist

11. Industry or business

FATHER — 12. Name: J. Henson Beachley

13. Birthplace: Middletown, Fred. Co. Md.

MOTHER — 14. Maiden name: Anna Knode

15. Birthplace: Funkstown, Maryland

16. Informant: Mrs. William E. Beachley

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-10-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Mausoleum

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. July 11 19 45 (Date rec'd by registrar) C. Croft Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 19 44, at 4½ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 44 to July 8 19 44

and that I last saw h[illegible] alive on July 8 19 44

Immediate cause of death: Cerebral Sclerosis — DURATION: 1 yr.

Due to:

Due to:

Other conditions: General Arterio Sclerosis. — 5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D. H. Beachley M. D. or [illegible]

Address: Hagerstown Md. Date signed July 8 1944

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3rd)

CERTIFICATE OF DEATH

07297 10

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Ha gerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 years
Hospital, Institution, or street address where death occurred: 630 W. Washington St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 630 W. Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME: Mary M. Bell

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William H. Bell
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 18, 1862

8. AGE: Years	Months	Days	If less than one day
83	3	17	..... hrs. ..... min.

9. Birthplace: Near Clea rspring Wash. Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: David Long
13. Birthplace: Unknown

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Mr. Donald T. Bell
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 7, 1945 (month) (day) (year)
Cemetery or crematory: Riverview
Location: Williamsport Md.

18. Funeral director: Scott F. Minnich & Son
Address: Hagerstow Md.

19. July 5. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1945 at 1:30a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 1945 to July 5 1945
and that I last saw h alive on July 4 1945

Immediate cause of death	DURATION
Chronic Endocardit.	1 y.
arterio. sclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: V. Miller
DR VICTOR D. MILLER M. D. or other
Address 131 W. WASHINGTON, ST. Date signed 7-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. S. Earl Young 42

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ 07298

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Washington
City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Years
Hospital, institution, or street address where death occurred: 836 West Washington St.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)
Street No. 836 West Washington St. (If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Preston Winfield Berger

3.(b) Social Security Number 705-10-6822

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Rubie Miller
6.(c) If alive, give age 41 years
7. Birth date of deceased (mo., day, yr.) May 28 1901

8. AGE: Years	Months	Days	If less than one day
44	1	28	....hrs. ....min.

9. Birthplace Reid W'sh. Co. Md. (Town, county, and state)
10. Usual occupation Machinist
11. Industry or business W.M.R.R.
FATHER 12. Name J. Emanuel Berger
FATHER 13. Birthplace Reid Md.
MOTHER 14. Maiden name Mintie Hershey
MOTHER 15. Birthplace Zullinger Pa.
16. Informant Mrs. Rubie M. Berger
Address Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/29/45 (month) (day) (year)
Cemetery or crematory Rest Haven Cemetery
Location Hagerstown Md.
18. Funeral director Andrew K. Coffman
Address Hagerstown Md.
19. July 28. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH July 26 1945 at 10.30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/24/45 to 7/26/45
and that I last saw h... alive on 7/26/45

Immediate cause of death	DURATION
Coronary Occlusion	48 hrs.
Due to	
Due to	
Other conditions Coronary Arteriosclerosis Unknown	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury Injured at work?

23. SIGNATURE S. Earl Young M.D. M.D. or other
Address Hagerstown Md. Date signed 7/27/45

43

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

07299

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washkngton County Hospital

How long in hospital or institution? 1day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Leitersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) ~~If veteran, name war~~ Route 5

3. (a) FULL NAME

Baby Boy Brown

3. (b) Social Security Number

0000000000

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 26, 1945

8. AGE: Years	Months	Days	If less than one day
		1	..... hrs. ..... min.

9. Birthplace: Hagerstown, Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Charles Edward Kauffman

13. Birthplace: Leitersburg Md.

MOTHER — 14. Maiden name: Beulah Jane Brown

15. Birthplace: Leitersburg, Md

16. Informant: Beulah Jane Brown

Address: Leitersburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 28, 1945 (month) (day) (year)

Cemetery or crematory: Belvue

Location: Hagerstown

18. Funeral director: Fred W. Kraiss.

Address: Hagerstown

18. July 28 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 19 45 at P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26, 1945 19 ..., to July 27, 19 45

and that I last saw him alive on July 27, 19 45

Immediate cause of death	DURATION
Premature birth	
(7 months gestation)	
Due to: Premature rupture of membranes	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: none Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R B Norment M.D. M. D. or other

Address: Hagerstown, Md. Date signed July 28, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

#1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

07300

Reg. Diat. No. 301

1. PLACE OF DEATH:

County: Washington

City or town: Virginia Ave, near Williamsport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Near Williamsport, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Virginia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Margaret E. Campbell

3. (b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Randolph Campbell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 1, 1868.

8. AGE: Years	Months	Days	If less than one day
77	7	0000	hrs. min.

9. Birthplace: Summit Point, W.Va. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: Vance Whittington

FATHER 13. Birthplace: West Virginia

MOTHER 14. Maiden name: Anna Hodge

MOTHER 15. Birthplace: West Virginia.

16. Informant: Mrs. Ethel Reno

Address: Hagerstown.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 3 1945 (month) (day) (year)

Cemetery or crematory

Location: Bolivar, W.Va.

18. Funeral director: Fred W. Kraiss.

Address: Hagerstown.

19. Aug 2 1945 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 1945 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/20/45 to 7/31/45

and that I last saw h alive on 7/30/45

Immediate cause of death	DURATION
Congestive Heart Failure	7 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Earl Young M.D. M. D. or other

Address: 7/24/45 Hagerstown Md Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-d)

CERTIFICATE OF DEATH

★ 07301 Reg. Dist. No. 30 2

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, Institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. R#1 Raven Heights
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: George Leondis Carden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Virginia C
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Feb 8, 1864

8. AGE: Years	Months	Days	If less than one day
81	6	11	..... hrs. ..... min.

9. Birthplace: Oldtown, Allegany Co. Md
(Town, county, and state)
10. Usual occupation: Medical Doctor
11. Industry or business: Retired

FATHER
12. Name: John W. Carden
13. Birthplace: Virginia

MOTHER
14. Maiden name: Julia A. Neely
15. Birthplace: Virginia

16. Informant: Robert C. Carden
Address: R#4 Hagerstown. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md
18. Funeral director: Frank Stein
Address: Cumberland, Md

19. July 19 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1945, at 12.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1945, to July 19 1945, and that I last saw him alive on July 19 1945.

Immediate cause of death	DURATION
Terminal Bronchopneumonia	1 day
Due to Chronic Myocarditis	1 yr.
Due to Hypertrophied prostate	10 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hagerstown Md Date signed 7/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Yeager

21

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

07302

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Years
Hospital, institution, or street address where death occurred:
101 Bellvieu Ave
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 101 Bellvieu Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Charles Edwin Carper

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bernice
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): July 21 1868

8. AGE: Years	Months	Days	If less than one day
76	11	20	....hrs. ....min.

9. Birthplace: Winchester Fred. Co. Va.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: -

FATHER
12. Name: Polk Carper
13. Birthplace: Winchester Va.

MOTHER
14. Maiden name: Sarah Grimm
15. Birthplace: Winchester Va.

16. Informant: Myrtle Carper
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/13/45 (month) (day) (year)
Cemetery or crematory: Mt. Hebron Cemetery
Location: Winchester Va.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. July 12 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1945 at 11 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 21, 1945 to July 11, 1945
and that I last saw h... alive on July 7, 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1½ hrs
Due to: Cerebral Hemorrhage & Hemiplegia - Rt.	June 21, 1945
Due to: Arteriosclerosis	10 yrs. ±
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: None
Date of op. No
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. Howard Yeager M. D. or other
Address: Hagerstown, Md. Date signed 7-13-45

no 1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 307 — 07303

1. PLACE OF DEATH:

County Washington

City or town Williamsport Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 203 Artizan
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Martha Elizebeth Castle

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	marrwidowed

6.(b) Name of husband or wife Charles Castle — 6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 30 1864

8. AGE: Years	Months	Days	If less than one day
80	11	3	... hrs. ... min.

9. Birthplace Mooresville Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER — 12. Name John Miller

13. Birthplace Md

MOTHER — 14. Maiden name Ellen Bridendolph

15. Birthplace Md

16. Informant Frank Castle

Address Williamsport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6 1945 (month) (day) (year)

Cemetery or crematory Riverview Cem

Location Williamsport Md

18. Funeral director Edith V. Leaf

Address Williamsport Md

19. July 6 1945 (Date rec'd by registrar) Mrs. E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1945, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1945 to July 3 1945 and that I last saw h... alive on July 3 1945

	DURATION
Immediate cause of death Uremia	2 hrs.
Due to Ulcerative Cystic Carcinoma	
Due to Casular Heart Disease	2 yrs.
Due to None	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C P Young M. D. or other

Address Williamsport Md Date signed 7/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

28

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (K&E)

07304

CERTIFICATE OF DEATH

★ Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstoen

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Wood Point

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

~~Still Born~~ child of Lewis W. Colbert

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 16, 1945

8. AGE: Years: Born alive - ~~Still Born~~ | Months | Days | If less than one day: 0 hrs. 5 min.

9. Birthplace: Hagerstown, Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Lewis W. Colbert

FATHER — 13. Birthplace: Elkins, W. Va.

MOTHER — 14. Maiden name: Catherine V. Hutzell

MOTHER — 15. Birthplace: Maryland

16. Informant: Lewis W. Colbert

Address: Hagerstown,

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Hagerstown

18. Funeral director: Fred W. Kraiss

Address: Hagerstown.

19. July 18, 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16, 1945, at 12-30 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16, 1945, to July 16, 1945

and that I last saw him alive on July 16, 1945

Immediate cause of death	DURATION
Premature Birth of	6½ hrs.
Due to Breech -	
Due to baby did not arrive until 30 minutes after birth - Baby treated	
Other conditions one time according to grandmother -	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Howard Stultz M.D. M. D. or other

Address: Hagerstown Md Date signed: 7/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

07305 No 4

★ Reg. Diat. No. 305

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Boonsboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
in Doctors office
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Fairplay - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Fairplay Route 1
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: William Harrison Cunningham

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Florence Cunningham
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April - 5 - 1871

8. AGE: Years	Months	Days	If less than one day
74	3	16	hrs. min.

9. Birthplace: near Broadfording Washington Co. Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Own Farm
12. Father — Name: John Cunningham
13. Father — Birthplace: Leesburg Washington Co. Md.
14. Mother — Maiden name: Sarah Gordon
15. Mother — Birthplace: Pennsylvania
16. Informant: Mrs. Joseph Berkenbaugh
Address: Fairplay Md. R.1
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24, 1945 (month) (day) (year)
Cemetery or crematory: Lutheran Cemetary
Location: Bakersville Md.
18. Funeral director: M. J. Bast & Sons
Address: Boonsboro Md.
19. July 23, 1945 John L. Bast
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21st 1945, at 9:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20th 1945, to July 21st 1945
and that I last saw h... alive on July 10th 1945

Immediate cause of death	DURATION
Acute Coronary Occlusion	24 Minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hubert Nadler M.D.
M. D. or other
Address: Boonsboro, Md. Date signed 7/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. conrad 2

07316

★ Reg. Dist. No. 305

1. PLACE OF DEATH:
County Washington
City or town Breathedsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Year
Hospital, Institution, or street address where death occurred:
Md. State Ref. for Males
How long in hospital or institution? 1 Year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Marylend County Baltimore
City or town Baltimore ville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 589 West Oxford St.
(If rural, give LOCATION)
2.(a) If veteran, name war None ✓

3. (a) FULL NAME John Henry Curry

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife --

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 9 1921

8. AGE: Years	Months	Days	If less than one day
24	0	3	...hrs. ...min.

9. Birthplace Dothan Houstin Co. Ala. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business —

FATHER
12. Name No Record
13. Birthplace No Record

MOTHER
14. Maiden name Willie Mae Haynes
15. Birthplace Louisville Ala.

16. Informant Records Md. State Ref. for Males
Address Breathedsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14,45 (month) (day) (year)
Cemetery or crematory Louisville Cemetery
Location Louisville Ala.

18. Funeral director Andrew K. Coffman
Address Hagerstown, Md.

19 July 13 1945 (Date rec'd by registrar) John H. Caal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1945 19... at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 45, to July 13 19 45
and that I last saw h...liv...alive on July 11 19 45

Immediate cause of death	DURATION
Acute Rheumatic Fever	5 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Robert P. Conrad, M.D. M. D. or other
Address Hagerstown, Md Date signed 7-12-45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (36)

07307 19

CERTIFICATE OF DEATH

★ Reg. Dist. No. 30 2

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months

Hospital, Institution, or street address where death occurred:

855 Mulberry Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Washington

City or town Hagerstown Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 855 Mulberry Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James H. Dunn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife

March 24, 1943 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1913

8. AGE: Years	Months	Days	If less than one day
32	3	14	hrs. min.

9. Birthplace Mt. Savage Allegany Co. Md (Town, county, and state)

10. Usual occupation Invalid was high school graduate

11. Industry or business from school

FATHER 12. Name James Dunn

13. Birthplace Mt. Savage Md

MOTHER 14. Maiden name Mary Raidler

15. Birthplace Mt. Savage Md

16. Informant James Dunn

Address 855 Mulberry Ave Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/13/45 (month) (day) (year)

Cemetery or crematory St. George Memorial Cemetery

Location Mt. Savage Allegany Co Md

18. Funeral director Walter H. Gantz

Address 27 E. Church St. Waynesboro, Pa

19. July 10 1945 Fred H. Bovard

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1945 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945 to July 10, 1945 and that I last saw h[illegible] alive on July 10, 1945

Immediate cause of death Chr. Polio-encephalitis — DURATION 10-15 years

Due to

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operation No operation Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. A. Beer M. D. or other

Address Hagerstown Md Date signed 7/10/45

119 N. Stevens St
Ida Bell

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07308

3.

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington

City or town Keedysville Route no-1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Keedysville md. R. 1

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Frank Rosser Fleet

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Bessie N. Fleet

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) March 26th 1875

8. AGE:

Years	Months	Days	If less than one day
70	3	19	....hrs. ....min.

9. Birthplace Winchester Frederick Co Va

(Town, county, and state)

10. Usual occupation

11. Industry or business Farmer

FATHER

12. Name Charles F. Fleet

13. Birthplace Winchester Va

MOTHER

14. Maiden name Frances Lowery

15. Birthplace Winchester Va

16. Informant Bessie Fleet

Address Keedysville Route -1

17. Burial (Burial, cremation, or removal. Which?) Date thereof July - 17th (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md

18. Funeral director A K Leffler

Address Hagerstown Md

19. July 15 1945 (Date rec'd by registrar) John H. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 19 45 at 5.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 19 45 to July 15 19 45 and that I last saw him alive on July 2 19 45

Immediate cause of death	DURATION
Carcinoma of prostate.	2 yrs.
Due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G W Sellers M. D.

M. D. or other

Address Boonsboro Date signed July 15, 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

07309

12

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in abeve place of death? 2 Years
Hospital, Institution, er street address where death occurred:
926 Oak Hill Ave
How long in hospital er institution? –

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 926 Oak Hill Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME
Mrs. Ida Kime Forney

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband er wife: Harvey C.
6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): August 27 1874

8. AGE: Years	Months	Days	If less than one day
70	11	8	....hrs. ....min.

9. Birthplace: Harrisburg Dauphin Co. Pa.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Samuel Kime
13. Birthplace: Harrisburg Pa.

MOTHER
14. Maiden name: No Record
15. Birthplace: No Record

16. Informant: Mrs. John G. Todd
Address: Hagerstown Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 7/7/45 (month) (day) (year)
Cemetery or crematory: East Harrisburg cemetery
Location: Harrisburg Pa.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. July 5 1945 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5, 1945, at 7 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 26, 1945 to July 5 1945
and that I last saw her alive on July 3, 1945

Immediate cause of death	DURATION
Chronic Myocarditis with congestive failure	1 yr.
Due to	
Due to	
Other conditions: Chronic Nephritis	Indef
Diabetes Mellitus	Indef.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: B B Sweeney M.D.
M. D. or other
Address: 148 W. Washington St., Hagerstown, Md. Date signed 7/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Stauffer 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

07310

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
1199 The Terrace
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1199 The Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Miss Gertrude Anna Frazer

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): April 29 1877

8. AGE: Years	Months	Days	If less than one day
68	3	2	...hrs. ...min.

9. Birthplace: Lockport Niagara Co. N.Y.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER
12. Name: John J. Frazer
13. Birthplace: Canada

MOTHER
14. Maiden name: Anna Doty
15. Birthplace: Lockport N.Y.

16. Informant: Mrs John J. Porter
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/1/45 (month) (day) (year)
Cemetery or crematory: Family Grave Yard
Location: Glenn Forney Pa.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. July 30 1945 (Date rec'd by registrar) Elsie H. Bovard Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH: July 30 1945 at 11 a.m. 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 1945 to July 30 1945 and that I last saw h...r alive on July 29 1945

Immediate cause of death	DURATION
Carcinoma of	
Due to Left Mammary Gland	
Due to —	
Other conditions ✓	

(Include pregnancy within 3 months of death)

Major findings of operations ✓

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A P Hamilton M. D. or other
Address: Hagerstown Md. Date signed July 30 1945

(M) MARGIN RESERVED FOR BINDING (1) (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 486

07311

37

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown R D 3 Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 years

Hospital, institution, or street address where death occurred:
Cearfoss Pike

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown Rural R D 3
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Cearfoss Pike
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lillian Ann French

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William I. French

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 1, 1892

8. AGE:

Years	Months	Days	If less than one day
52	11	21	..... hrs. ..... min.

9. Birthplace: Washington County, Md.
(Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER — 12. Name: George N. Carbaugh

FATHER — 13. Birthplace: Wash. Co., Md.

MOTHER — 14. Maiden name: Ida Bloyer

MOTHER — 15. Birthplace: Wash. Co., Md.

16. Informant: William I. French

Address: Hagerstown, Md. R D 3

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24 45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. July 24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21, 1945 (month) (day) (year) at 2.20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct — 1944, to July 21 — 1945 and that I last saw h[illegible] alive on July 20 — 1945

	DURATION
Immediate cause of death:	
Due to: Carcinoma of Uterus	10 Mos
Due to: Uremic Metastasis	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Hoagy P Kratz M. D. or other

Address: Hagerstown Md Date signed 7/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 80-E

CERTIFICATE OF DEATH

Dr. Yeager 8

07312

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Year
Hospital, institution, or street address where death occurred:
126 Elm St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 126 Elm St
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Mrs. Mary Catherine French

3.(b) Social Security Number 214-09-1644

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Elmer A.
6.(c) If alive, give age —
7. Birth date of deceased (mo., day, yr.) September 18 1896

8. AGE: Years	Months	Days	If less than one day
48	10	11	..... hrs. ..... min.

9. Birthplace Clearspring Wash. Co. Md.
(Town, county, and state)
10. Usual occupation Stitcher
11. Industry or business Southern Shoe Co.
FATHER 12. Name John Spercher
13. Birthplace Clearspring Md.
MOTHER 14. Maiden name Myrtle Weaver
15. Birthplace Big Pool Md.
16. Informant Mrs. Elma Kretzer
Address Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/3/45 (month) (day) (year)
Cemetery or crematory Little Rose Hill Cemetery
Location near Clearspring Md
18. Funeral director Andrew K. Coffman
Address Hagerstown Md.
19 July 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30, 1945, to July 1, 1945 and that I last saw h.. alive on June 30, 1945

Immediate cause of death	DURATION
Encephalitis Acute Affecting Left Cerebellum - Func. 1070	2 days
Due to Paralysis Right arm & Leg	Aug. 1944
Due to Paralysis Agitans Hypodermic	" 1944 Feb. 1945
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations None Date of op. —
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Howard Yeager M. D. or other
Address Hagerstown Md. Date signed July 4, 1945.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E)

CERTIFICATE OF DEATH

07313

Reg. Dist. No. 302

11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington (WITHIN CORPORATE LIMITS)

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred: 761 S. Potomac Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Washington (WITHIN CORPORATE LIMITS)

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. 761 S. Potomac St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles L. Frownfelter

3.(b) Social Security Number: 214-09-3023

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emily Kate Frownfelter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feby. 11, 1874

8. AGE: Years	Months	Days	If less than one day
71	4	22	..... hrs. ..... min.

9. Birthplace: Washington County, Md. (Town, county, and state)

10. Usual occupation: Employee of City Light Plant

11. Industry or business

FATHER — 12. Name: Samuel D. Frownfelter

FATHER — 13. Birthplace: Wash. Co., Md.

MOTHER — 14. Maiden name: Not known

MOTHER — 15. Birthplace: Not known

16. Informant: Mrs. Kate Frownfelter

Address: 761 S. Potomac St.- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. July 5 1945 (Date rec'd by registrar) Chas. H. Howard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3, 1945 12:20 A. or P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 1945 to July 2 1945 and that I last saw him alive on July 2 1945

Immediate cause of death	DURATION
Pulmonary edema	
Due to: Cerebral embolism	
Due to: Carcinoma of the stomach	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Walter Seymour M.D. M. D. or other

Address: Hagerstown Md. Date signed: 7/3-45

07314 26

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH ★ Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
50 Elizabeth Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 50 Elizabeth Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Evangeline Ethel Fulk

3.(b) Social Security Number: 220-18-0782

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): October 27, 1911

8. AGE: Years	Months	Days	If less than one day
33	9	3	hrs. min.

9. Birthplace: Rockingham Co. Va. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Hagerstown Rubber Company

FATHER
12. Name: Phillip Fulk
13. Birthplace: Rockingham Co. Va.

MOTHER
14. Maiden name: Leona Reese
15. Birthplace: Rockingham Co. Va.

16. Informant: Mrs. Leona Carter
Address: Baltimore, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-17-45 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown, Maryland

18. Funeral director: C.M. Suter & Sons
Address: Hagerstown, Maryland

19. July 17 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

6:05

20. DATE OF DEATH: July 14 1945, at P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Gun shot wound of chest	
Due to: hemorrhage & shock	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of 7/14/45
Where did injury occur? Hagerstown (City or town) Wash. (County) Md. (State)
Injured at home, farm, Industry, public place (where?) Home - Elizabeth St
Means of injury: Gunshot Injured at work? No

DEPUTY MEDICAL EXAM. WASH. CO., MD.

23. SIGNATURE: L. Robert Wells M. D. or other
Address: Hagerstown, Md. Date signed 7/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

07315 3

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred:
540 N. Locust Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 540 N. Locust Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William H. Garvin

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Laura E. Garvin

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby. 2, 1867

8. AGE: Years 78 | Months 4 | Days 29 | If less than one day: hrs. min.

9. Birthplace: Franklin County, Pa.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: ---------- Garvin
13. Birthplace: ---------- Pennsylvania

MOTHER
14. Maiden name: Rebecca ----------
15. Birthplace: --------- Pennsylvania

16. Informant: Harry C. Garvin
Address: 540 N. Locust Street- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. July 2, 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1, 1945 7:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May - 9 1945, to May 1 1945 and that I last saw h. alive on May 1 1945

Immediate cause of death	DURATION
Cardio-Vascular-Renal Disease	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. A. Campbell M. D. or other

Address: Hagerstown Md Date signed: July 2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Porterfield 24

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

★ 7316 Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Years
Hospital, institution, or street address where death occurred:
272½ South Potomac St.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 272½ South Potomac St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Hattie Humrichouse Gentes

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Adolph
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 3 1868

8. AGE: Years	Months	Days	If less than one day
77	2	13	...hrs. ...min.

9. Birthplace: Funkstown Wash. Co. Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own Home
FATHER 12. Name: Edward P. Humrichouse
FATHER 13. Birthplace: Hagerstown Md.
MOTHER 14. Maiden name: Amelia Knode
MOTHER 15. Birthplace: Hagerstown Md.
16. Informant: Miss Anna Humrichouse
Address: Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/19/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. July 18 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: July 16 1945 19... at 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 19 45 to July 16 19 45 and that I last saw h... alive on July 16 19 45

	DURATION
Immediate cause of death: Cerebral Hemorrhage	7/16/45
Due to: Hypertension	?
Due to: Arteriosclerosis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: H. S. Porterfield M.D. M. D. or other
Address: 136 W Washington Date signed 7/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (406)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 383

67377

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
116 Fooke, st.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md., County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 116 Fooke st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ida Frances Harting

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Ernest H. Harting
6.(c) If alive, give age 37 years
7. Birth date of deceased (mo., day, yr.) Feb. 3-1915

8. AGE: Years	Months	Days	If less than one day
30	5	19	hrs. min.

9. Birthplace Salisbury Maryland (Town, county, and state)
10. Usual occupation Home life
11. Industry or business at Home

FATHER
12. Name Marion Francis Tindle
13. Birthplace Salisbury Maryland

MOTHER
14. Maiden name Hallie V. E. Wooldfield
15. Birthplace Montgomery C. Woodfield Md.

16. Informant Mr. Ernest H. Harting
Address 116 Fooke, st. Salisbury, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25-1945 (month) (day) (year)
Cemetery or crematory Parsons Cemetery
Location Salisbury Maryland
18. Funeral director Holloway & Walter K. Holloway
Address Salisbury Maryland.
19. 7/23/45 (Date rec'd by registrar) Margaret E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22nd 1945 at 5.45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1945, to July 22 1945 and that I last saw him alive on July 22 1945

	DURATION
Immediate cause of death Peritonitis	5 days
Due to Septic abortion & ruptured uterus	6 weeks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations D & C - Ruptured uterus immediate hysterectomy Date of op. 7-8-45
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. A. Rodemeyer M.D. M. D. or other
Address Salisbury Md. Date signed 7/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

14

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

07317

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:
20 West Baltimore Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 20 West Baltimore Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harry L. Heleine

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Laura E. Heleine

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 4, 1869

8. AGE:	Years	Months	Days	If less than one day
	76	1	29	..... hrs. ..... min.

9. Birthplace Hagerstown, Wash.Co.Md.
(Town, county, and state)

10. Usual occupation Retired Merchant

11. Industry or business

FATHER 12. Name Phillip Heleine

13. Birthplace Hagerstown, Maryland

MOTHER 14. Maiden name Louisa Davis

15. Birthplace Hagerstown, Maryland

16. Informant Mrs. Harvey Wachter

Address Hagerstown, Maryland

17. Burial Date thereof 7-7-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. July 5. 1945 Chas. H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1945, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 1945 to July 3 1945

and that I last saw him alive on July 3 1945

Immediate cause of death	DURATION
Chronic Endocarditis	?
" Nephritis	?
Due to Arterio	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Victor D. Miller
DR. VICTOR D. MILLER, M. D. or other

Address 131 W. WASHINGTON, ST. Date signed 7-5-1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. U. D. Miller

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07318

Reg. Dist. No. 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Williamsport,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Williamsport, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 29 W Salisbury St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: George W Herbert

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Belle Herbert
6.(c) If alive, give age: 74 yrs years

7. Birth date of deceased (mo., day, yr.): Oct. 2 1870

8. AGE: Years	Months	Days	If less than one day
74	9	14	...hrs. ...min.

9. Birthplace: Falling Waters W. Va.
(Town, county, and state)
10. Usual occupation: Leather Grainer
11. Industry or business: Tannery Willlamposrt

FATHER
12. Name: William Herbert
13. Birthplace: Falling Waters W. Va.

MOTHER
14. Maiden name: Elizabeth Kershner
15. Birthplace: Falling Waters W. Va.

16. Informant: Anna Belle Herbert (wife)
Address: 29 W Salisbury St. Williamsport

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 21 1945 (month) (day) (year)
Cemetery or crematory: Riverview Cemetery
Location: Williamsport, Maryland

18. Funeral director: Edith V Leaf
Address: #7 Church St. Williamsport, Md.

19. July 21 1945 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

(10)

20. DATE OF DEATH: July 17 1945 at 90 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1 1945 to July 17 1945
and that last saw h... alive on July 17 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hour
Due to: Arteriosclerosis	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Williamsport Md. Date signed: 7/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

07319 1

★ Reg. Dist. No. 307

1. PLACE OF DEATH:

County Washington

City or town Rural Brownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Washington

City or town Rural Brownsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles H. Hoffmaster

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 3, 1868

8. AGE: Years	Months	Days	If less than one day
77	0	19	...hrs. ...min.

9. Birthplace Brownsville, Washington Co., Md.
(Town, county, and state)

10. Usual occupation Retired Railroad Carinspector

11. Industry or business

FATHER
12. Name George W. Hoffmaster
13. Birthplace Cabletown, Va.

MOTHER
14. Maiden name Rachel Cavn
15. Birthplace Cecil County, Md.

16. Informant Iona Hoffmaster

Address Brownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-25-45 (month) (day) (year)

Cemetery or crematory Episcopal Cemetery

Location Brownsville, Md

18. Funeral director Gladhill Co.

Address Middletown, Md.

19. July 25 (Date rec'd by registrar) 1945 Cornelius H. Castle Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22" 1945 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 19" 1933 to July 22" 1945

and that I last saw h... alive on June 14" 1945

Immediate cause of death Cerebral Hemorrhage — DURATION 11 yr. 7 m. 3 da.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Herbert Nash M.D.
M. D. or other

Address Boonsboro, Md Date signed 7/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07320

Reg. Dist. No. 302

9

1. PLACE OF DEATH:
County Washington Co.
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 520 W. Franklin St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 520 W. Franklin
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Matthew Hogan

3.(b) Social Security Number: 705-10-6788

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Julia Neibert
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Oct. 10th 1875

8. AGE: Years	Months	Days	If less than one day
69	8	21	hrs. min.

9. Birthplace: Buena Vista, Va.
(Town, county, and state)
10. Usual occupation: Retired Engineer
11. Industry or business: Rail Road
FATHER 12. Name: William A. Hogan
13. Birthplace: Rock Ridge Co. Virginia
MOTHER 14. Maiden name: Mary Sullivan
15. Birthplace: Rock Ridge Co. Virginia
16. Informant: Mrs. Lawrence Finley
Address: 255 S. Potomac St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3-1945 (month) (day) (year)
Cemetery or crematory: Rest Haven
Location: Hagerstown Md.
18. Funeral director: L. F. Roecher
Address: Funkstown Md.
19. July 3 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1945 at 1.40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3 1944 to June 30 1945 and that I last saw him alive on June 30 1945

Immediate cause of death	DURATION
Cardio-Vascular Disease	2 years.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. Campbell M. D. or other
Address: Hagerstown Md. Date signed July 2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07321 23

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH ★

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 days

Hospital, institution, or street address where death occurred:

17 Elizabeth Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 Elizabeth Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Minnie Florence Holsinger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William E. Holsinger

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): June 29, 1882

8. AGE: Years	Months	Days	If less than one day
63	0	16	....hrs. ....min.

9. Birthplace: Near Broadford, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: John Hideacker

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Emma Martz

MOTHER 15. Birthplace: Virginia

16. Informant: William E. Holsinger

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-18-45 (month) (day) (year)

Cemetery or crematory: Broadingford Church Cem.

Location: Broadingford, Maryland

18. Funeral director: Louis F. Reecher

Address: Funkstown, Maryland

19. July 16 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1945, at ....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1944 19.. to July 15 1945

and that I last saw h.. alive on July 14 1945 19..

Immediate cause of death	DURATION
Chr. Myocarditis	3 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Hagerstown Md Date signed 7/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Wells 16

07322

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, Institution, or street address where death occurred:
Leitersburg pike
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Leitersburg Pike
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: David Cline Horn

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Emma.
6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): May 2 1871

8. AGE: Years	Months	Days	If less than one day
74	2	0	hrs. min.

9. Birthplace: Sheperdstown Berkley Co. W. Va.
(Town, county, and state)
10. Usual occupation: Operator
11. Industry or business: Filling Station
FATHER 12. Name: David Horn
13. Birthplace: Shepherdstown W. Va.
MOTHER 14. Maiden name: Mary C. Crider
15. Birthplace: Shepherdstown W. Va.
16. Informant: Charles E. Horn
Address: Hagerstow n Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 /8/45 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemeteryy
Location: Hagerstown Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. July 6, 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1945, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3 1939 to June 29 1945 and that I last saw him alive on June 29 1945

Immediate cause of death	DURATION
Coronary Sclerosis	1 Yr
Due to: acute coronary occlusion	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: S. Robert Wells M.D.
M. D.
Address: Hagerstown, Md. Date signed: 7/6/45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1)

(7)

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

07323

Reg. Dist. No. 304

1. PLACE OF DEATH:
County: Washington
City or town: Hancock R7D2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mo.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hancock R7D2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Earl L. Hull Jr.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16 - 1945

8. AGE: Years	Months	Days	If less than one day
	5	28	hrs. min.

9. Birthplace: Washington Co. (Town, county, and state)

10. Usual occupation: Infant.

11. Industry or business

FATHER 12. Name: Earl L. Hull

13. Birthplace: Washington Co.

MOTHER 14. Maiden name: Catherine McCusker

15. Birthplace: Pennsylvania

16. Informant: Earl L. Hull

Address: Hancock Md R7D2

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16 - 1945 (month) (day) (year)

Cemetery or crematory: Stone Bridge Dunkard

Location: near Hancock Md

18. Funeral director: Snyder Rowland

Address: Hancock, Md

19. July 16 1945 J. A. Heller Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 1945 at 8:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 14 1945 and that I last saw h.i.m. alive on July 13 1945

Immediate cause of death	DURATION
A	
Due to: Cerebral Embolism	
Due to: Convulsions	
Other conditions: Epilepsy	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E M Slaffer M. D. or other

Address: Hancock Date signed 7/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

07324

Reg. Dist. No. 303

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Clearspring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Clearspring
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elsie E. Kinsell

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of ~~husband~~ or wife: B.N.Kinsell

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 21 1878

8. AGE: Years	Months	Days	If less than one day
66	7	14	hrs. min.

9. Birthplace: Franklin Co. Pa.
(Town, county, and state)

10. Usual occupation: Home Work

11. Industry or business

FATHER
12. Name: Abraham Saylor
13. Birthplace: Franklin Co. Pa.

MOTHER
14. Maiden name: Alice L. Bower
15. Birthplace: Washington Co.

16. Informant: Mr. B.N. Kinsell
Address: Clearspring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6 1945 (month) (day) (year)

Cemetery or crematory: St. Pauls Cemetery

Location: Near Clearspring, Md.

18. Funeral director: Snyder-Rowland

Address: Clearspring, Md.

19. July 5 1945 (Date rec'd by registrar) Joseph W. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4 1945, at 7:40A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from FEBRUARY 19 1938 to July 4 1945 and that I last saw h~~e~~r alive on July 3 1945

Immediate cause of death	DURATION
CEREBRAL EMBOLUS	12 days
Due to: AURICULAR FIBRILLATION, CHRONIC	7 YEARS
Due to: POPLITEAL EMBOLUS, RIGHT	5 mos.
Other conditions: CHRONIC NEPHRITIS WITH HYPERTENSION.	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE.

Date of op.

Autopsy results: NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Annie Bower Cohen M. D.

Address: Clearspring Md. Date signed 7/4/45

Evidence for change of year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-04)

CERTIFICATE OF DEATH

07325

FILM No. G 97 AUG 3 1945

Reg. Diat. No. 301

1. PLACE OF DEATH:

County: Washington County

City or town: Williamsport, Maryland
(If outside city or towo limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs

Hospital, institution, or street address where death occurred:
Williamsport, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro infants give resideoce of mother)

State: Maryland County: Washington

City or town: Conococheague St. Williamsport
(If outside city or town limits, write RURAL aod give nearest town)

Street No. Conococheague St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Edward Klipp

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Grace Klipp
deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 16 1874 1871

8. AGE: Years	Mooths	Days	If less than one day
74		10	hrs. min.

9. Birthplace: Chambersburg Pa.
(Town, coonty, and state)

10. Usual occopation: Forman at Tannery

11. Industry or bosiness: Tannery Williamsport

FATHER
12. Name: Fredreck Klipp
13. Birthplace: Chambersburg Pa.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Pa.

16. Informant: George Klipp (son)
Address: Conocheague St Williamsport, Md

17. Burial (Burial, crematioo, or removal. Which?) Date thereof July 29 1945 (mooth) (day) (year)
Cemetery or crematory: Riverview Cemetery
Location: Williamsport, Maryland

18. Funeral director: Edith V Leaf.
Address: #7 Church St. Williamsport, Md.

19. July 29 1945 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/26/45 19.. at 1P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/16/45 19.. to 7/26/45 19..
and that I last saw h.. alive on 7/26/45 19..

Immediate cause of death	DURATION
Pulmonary Edema Cardio Vascular Renal Disease	2 MO.
Due to	
Due to	
Other conditions	

(Ioclode pregnancy within 3 months of death)

Major findings of operatioos: Date of op.

Aotopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. P. Young M. D. or other
Address: Williamsport, Md. Date signed 7-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1)

(T)

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-C)

07326

CERTIFICATE OF DEATH

★ Reg. Diat. No. 3er

1. PLACE OF DEATH:
County Washington County
City or town Sharpsburg Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 88 yrs
Hospital, institution, or street address where death occurred:
Sharpsburg Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. Sharpsburg Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles William Lakin

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lily May Lakin
6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) June 29 1857

8. AGE: Years	Months	Days	If less than one day
88		18	hrs. min.

9. Birthplace Sharpsburg Maryland (Town, county, and state)
10. Usual occupation Shoe Factory (hand stitcher
11. Industry or business Shoe & Legging Factory

FATHER
12. Name Jacob Lakin
13. Birthplace Sharpsburg Md

MOTHER
14. Maiden name Amanda Porter
15. Birthplace Sharpsburg Md.

16. Informant Lily May Lakin
Address Sharpsburg Maryland

17. Burial Date thereof July 20 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mountain View
Location S harpsburg Md

18. Funeral director
Address

19. 7-20 1945 Ed. Boyer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1945 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1929 to 7/17 1945
and that I last saw h alive on July 16, 1945

Immediate cause of death	DURATION
Carcinoma of the Prostate	2 yrs.
Due to	
Due to	
Other conditions Blindness Cataracts	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter H. Shealy M.D.
M./D. or other
Address Sharpsburg, Md Date signed 7/18/45

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

07327

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 52 years
Hospital, institution, or street address where death occurred: 709 West Church Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 709 West Church Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph F. Lingg

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katherine M. Lingg
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): July 8, 1867

8. AGE:	Years	Months	Days	If less than one day
	78	0	20	...hrs. ...min.

9. Birthplace: Emmittsburg, Maryland (Town, county, and state)
10. Usual occupation: Retired Bricklayer
11. Industry or business

FATHER
12. Name: Henry Lingg
13. Birthplace: Emmittsburg, Maryland

MOTHER
14. Maiden name: Virginia Rider
15. Birthplace: Emmittsburg, Maryland

16. Informant: Mrs. Joseph F. Lingg
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-31-45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. July 30. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1945, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1-45 19..., to July 28-45 19...
and that I last saw h... alive on July 28-45 19...

Immediate cause of death	DURATION
Cardiac Decompensation	3 wks
Due to	
Due to Arteriosclerosis	2 yrs
Other conditions Chr Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: W. M. Suter M. D. or other
Address: Hagerstown Md. Date signed 7-30-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

07328 7

Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown (WITHIN CORPORATE LIMITS)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, Institution, or street address where death occurred:
Washington Co Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Washington
City or town: Hagerstown (WITHIN CORPORATE LIMITS)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 115 Buena Vista ave
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish-american War

3.(a) FULL NAME: W. HARRY LONG

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 20 1869

8. AGE: Years	Months	Days	If less than one day
75	10	12	..... hrs. ..... min.

9. Birthplace: Greencastle
(Town, county, and state)

10. Usual occupation: machinist

11. Industry or business: Self

FATHER — 12. Name: William H Long
13. Birthplace: Greencastle

MOTHER — 14. Maiden name: Sarah E. Garman
15. Birthplace: Cumberland Co Pa

18. Informant: Mrs. A. M. Stauffer
Address: Greencastle Pa

17. B (Burial, cremation, or removal. Which?) Date thereof July 5 45 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: near Greencastle

18. Funeral director: R E Minnich

Address: Greencastle Pa

19. July 3 1945 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2, 1945, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1945 to July 2 1945
and that I last saw h[illegible] alive on July 2 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	6 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation

Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: W. McAllan Brown M. D. or other

Address: 164 W Wash Date signed 7-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

#3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (837)

CERTIFICATE OF DEATH

07329

Reg. Dist. No. 361

1. PLACE OF DEATH:
County: Washington County
City or town: Williamsport, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, institution, or street address where death occurred:
#9 S. Potomac St. Williamsport, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Williamsport,
(If outside city or town limits, write RURAL and give nearest town)
Street No. #9 S. Patomac St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Beard Mentzer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sarah McCoy Mentzer
Deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ~~July 22 1945~~ Oct. 15, 1861

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
83 yrs	9	7		

9. Birthplace: Near Clearspring Md.
(Town, county, and state)
10. Usual occupation: Broom Maker
11. Industry or business: Broom Factory
FATHER 12. Name: Christopher Mentzer
13. Birthplace: Maryland
MOTHER 14. Maiden name: Matilda Beard
15. Birthplace: Maryland
16. Informant: Meda Gasrrish (daughter)
Address: Conococheague St Williamsport
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24 1945 (month) (day) (year)
Cemetery or crematory: Riverview Cemetery
Location: Williamsport, Md.
18. Funeral director: Edith V Leaf
Address: #7 Church St Williamsport, Md.

19. July 24 1945 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1945, at 1 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1945, to July 22 1945 and that I last saw h... alive on July 22 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage.	2 days
Due to Arteriosclerosis.	2 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Williamsport Md. Date signed 7/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Ditto 25

07331

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH ★

Reg. Dist. No. 302

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Hours
Hospital, Institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 5 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 142 South Mulberry St
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: John E. Middlekauff

3.(b) Social Security Number: 216-~~None~~ 05-2416

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lelia K.
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): May 11 1884

8. AGE: Years	Months	Days	If less than one day
61	2	3	....hrs. ....min.

9. Birthplace: Fairplay Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: Own Employer
FATHER 12. Name: Aaron Middlekauff
13. Birthplace: Fairplay Md.
MOTHER 14. Maiden name: Laura Eakle
15. Birthplace: Fairplay Md.
16. Informant: Mrs. Lelia K. Middlekauff
Address: Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/16/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. July 16 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION A M

20. DATE OF DEATH: July 14 1945 19.... at 6.30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1- 45 to July 14 45
and that I last saw h... alive on July 14 45 19....

	DURATION
Immediate cause of death	
Coronary Sclerosis	6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: .... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hagerstown Md. Date signed 7/14/45

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07331

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 years
Hospital, Institution, or street address where death occurred: 57 W. Franklin St,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 57 W. Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Henry C. Monroe

3.(b) Social Security Number 214-09-0698

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Clara W. Monroe
6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Oct. 8 1878

8. AGE: Years	Months	Days	If less than one day
66	9	16	....hrs. ....min.

9. Birthplace Boonesboro Wash Md.
(Town, county, and state)
10. Usual occupation Salesman
11. Industry or business Retired

FATHER 12. Name Robert N. Monroe
FATHER 13. Birthplace Boonesboro Md.
MOTHER 14. Maiden name Sarah E. Hering
MOTHER 15. Birthplace Middletown Md.

16. Informant Mrs. Clara W. Monroe
Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof ~~Oct.~~ July 25, 1945 (month) (day) (year)
Cemetery or ~~crematory~~ Boonesboro Luthern
Location Boonesboro Md.

18. Funeral director Scott F. Minnich & Son
Address Hagerstown Md.

19. July 25 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1945 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 1942 to July 23 1945
and that I last saw him alive on July 23 1945

Immediate cause of death	DURATION
(a) Cerebral Hemorrhage	5/17/42
(b)	7/18/45
Due to: (a) Arteriosclerosis	
(b) Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H L Porterfield M.D. M. D. or other
Address 136 W Washington Date signed 7/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Dr W 17332 35

★ Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Jamison's Cold Storage Door Co.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Frederick
City or town: Rural — Smithsburg R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mt Wolfsville
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Floyd R. Moser

3.(b) Social Security Number: 215-12-9136

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mabel Poffenberger Moser 6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): July 25, 1896

8. AGE: Years: 48 Months: 11 Days: 24 If less than one day: hrs. min.

9. Birthplace: Foxville Fred. Co. Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Lewis Moser
13. Birthplace: Md

MOTHER
14. Maiden name: Viola Hayes
15. Birthplace: Md

16. Informant: Mrs L. R. Moser
Address: Smithsburg RR#1 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 22, 1945 (month) (day) (year)
Cemetery or crematory: Grossnickles
Location: W Ellerton Md.

18. Funeral director: J. Thomas Bittle & Son
Address: Boyersville Md.

19. July 20, 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute coronary occlsuion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: as above
Date of op. July 19 1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Robt. Wells DEPUTY MEDICAL EXAM WASH. CO., MD.
M. D. or ~~other~~
Address: Hagerstown, Md. Date signed: July 20/45

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2nd

07333

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place ot death? 60 years

Hospital, Institution, or street address where death occurred:
867 Virginia Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn Infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 867 Virginia Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lewis Blaine Mundey

3.(b) Social Security Number: 214 / 10 / 4211.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name ot husband or wife: Dorothy W. Mundey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 12, 1884

8. AGE: Years	Months	Days	If less than one day
60	8	4	..... hrs. ..... min.

9. Birthplace: Washington County, Md.
(Town, county, and state)

10. Usual occupation: Employee of Potomac Edison Co

11. Industry or business: Motorman

FATHER — 12. Name: Charles Mundey

FATHER — 13. Birthplace: Wash. Co., Md.

MOTHER — 14. Maiden name: Amanda Warden

MOTHER — 15. Birthplace: Wash. Co., Md.

16. Informant: Mrs. Dorothy Mundey

Address: 867 Va. Ave. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 20th 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. July 19 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16, 1945 8:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1- 1945 to July 16 1945 and that I last saw h... alive on July 16 - 1945 - 1945

Immediate cause of death	DURATION
Chronic Myocarditis	2 yr.
Cardiac asthma.	-
Due to: —	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Victor D. Miller
DR. VICTOR D. MILLER M. D. or other

Address: 131 W. WASHINGTON, S HAGERSTOWN, MD. Date signed: July 17, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 07334 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred: 600 N. Mulberry
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 600 N. Mulberry
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Annie M. Newcomer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 21 1864

8. AGE: Years	Months	Days	If less than one day
80	8	27	hrs. min.

9. Birthplace: Near Smithsburg Wash. Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: David Newcomer
13. Birthplace: Near Smithsburg Md.

MOTHER
14. Maiden name: Barbara A. Shank
15. Birthplace: Near Smithsburg Md.

16. Informant: Miss Emma S. Newcomer
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22.1945 (month) (day) (year)
Cemetery or crematory: Leitersburg Luthern Cemetery
Location: Leitersburg Md.

18. Funeral director: Scott F. Minnich & Son
Address: Hagerstown Md.

19. July 21. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1945 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1- 1945 to July 18 1945 and that I last saw him alive on July 18 1945

Immediate cause of death	DURATION
Cardiac	
Due to: Hemorrhage	5 wks
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: I. W. Stitt M. D. or other
Address: Hagerstown Md. Date signed 7/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

07335

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, Institution, or street address where death occurred:
119 Ray St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 119 Ray St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Nettie E Nunamaker

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widow

6.(b) Name of husband or wife: John A Nunamaker
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 3 - 1875

8. AGE: Years	Months	Days	If less than one day
70	2	3	hrs. min.

9. Birthplace: Marlow - Berkley - W Va
(Town, county, and state)
10. Usual occupation: Home duties
11. Industry or business:
FATHER 12. Name: Thomas Jordan
13. Birthplace: Unknown
MOTHER 14. Maiden name: Mary Rice
15. Birthplace: Unknown
16. Informant: Mrs. Viola Beall
Address: Hagerstown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 9-45 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown Md
18. Funeral director: Scott F. Minnick Son
Address: Hagerstown Md
19. July 7 1945 Chas H Boward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1945 at 10.30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Vascular hypertension	2 yrs
Due to: chr. myocarditis	1 yrs
Due to: acute ventricular fibrillation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J Robert Wells M. D.
DEPUTY MEDICAL EXAM WASH. CO., MD.
Address: Hagerstown, Md. Date signed: 7/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Ba)

CERTIFICATE OF DEATH

no 1

07336

Reg. Dist. No. 305

1. PLACE OF DEATH:
County: Washington
City or town: Tilghmanton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life.
Hospital, institution, or street address where death occurred: Fairplay R. 1
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Tilghmanton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Fairplay R. 1
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Mollie Missouri Palmer

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: David E. Palmer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 22. 1868

8. AGE:

Years	Months	Days	If less than one day
76	8	9	..... hrs. ..... min.

9. Birthplace: Tilghmanton Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: Own Home.
FATHER 12. Name: George Jacobs
13. Birthplace: Tilghmanton Wash. Co. Md.
MOTHER 14. Maiden name: Ellen Morgan
15. Birthplace: Tilghmanton Wash. Co. Md.
16. Informant: Mrs. Florence Palmer
Address: Fairplay Md. R. 1
17. Burial (Burial, cremation, or removal. Which?) Date thereof August 3, 1945 (month) (day) (year)
Cemetery or crematory: Manor Cemetary
Location: near Tilghmanton Md.
18. Funeral director: W. H. Bast & Sons
Address: Boonsboro Md.
19. August 2. 1945 (Date rec'd by registrar) John W. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 1945, at 10 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1945, to July 31 1945
and that I last saw h.em. alive on July 31 1945
Immediate cause of death: Cerebral Hemorrhage

	DURATION
Due to: Arteriosclerosis.	6 days
	10 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Williamsport Md. Date signed 8/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

5

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07337

CERTIFICATE OF DEATH

★ Reg. Dist. No. 303

1. PLACE OF DEATH:
County: Washington
City or town: Big Pool Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Big Pool Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Cethel Esther Peck

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Daniel R. Peck
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): April 8 1895

8. AGE: Years	Months	Days	If less than one day
50	3	14	...hrs. ...min.

9. Birthplace: Washington Co. (Town, county, and state)
10. Usual occupation: Home Work
11. Industry or business

FATHER
12. Name: Jacob Forsythe
13. Birthplace: Washington Co.

MOTHER
14. Maiden name: Roseanna Mills
15. Birthplace: Washington Co.

16. Informant: Daniel R. Peck
Address: Big Pool Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 25 1945 (month) (day) (year)
Cemetery or crematory: Tonoloway Baptist
Location: Fulton Co. Pa. (Near Hancock)

18. Funeral director: Snyder-Rowland
Address: Clearspring, Md.

19 July 23 19 45 (Date rec'd by registrar) Joseph W. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 19 45 at 11:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 19 45 to July 22 19 45 and that I last saw h... alive on July 8 19 45

Immediate cause of death	DURATION
Pulmonary T.B.	
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operation: ...Date of op.
Autopsy results:
PHYSICIAN: Please nuderline the cause to which death shonld be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F M Shaffer M.D. M. D. or other
Address: Hancock, Md. Date signed: 7/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07338 38

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1840)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs
Hospital, institution, or street address where death occurred: 240 N. Jonathan
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 240 N. Jonathan
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Laura Preston

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Feb 15 1867

8. AGE: Years 78 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Harrisonburg Va
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: 0
13. Birthplace 0

MOTHER
14. Maiden name 0
15. Birthplace 0

16. Informant: Hattie Maddison
Address 240 N. Jonathan St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown

18. Funeral director: William H. Downs
Address 291 Frederick St.

19. July 24, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 - July 19 - 1945, at - M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1945 to July 17 1945 and that I last saw h[illegible] alive on July 16 1945

Immediate cause of death	DURATION
Chronic Endocarditis	2
Replacement	
Due to: Arterio Sclerosis	1
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Victor D. Miller
DR. VICTOR D. MILLER M. D. or other
Address: 131 W. WASHINGTON, ST. Date signed: 7/18 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-7)

CERTIFICATE OF DEATH

07339

44

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Weeks

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Penna. County: Franklin

City or town: State Line

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Frederick Hagerman Renner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Melchora

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): August 5 1890

8. AGE: Years	Months	Days	If less than one day
54	11	24	...hrs. ...min.

9. Birthplace: Wilsons Wash. Co. Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Own Farm

FATHER — 12. Name: Lewis Renner

FATHER — 13. Birthplace: Clearsprings Md.

MOTHER — 14. Maiden name: Barbara Hagerman

MOTHER — 15. Birthplace: Hagerstown Md.

16. Informant: Mrs. Melchora Renner

Address: Greencastle Pa. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/31/45 (month) (day) (year)

Cemetery or crematory: St; Pauls Cemetery

Location: near Clearsprings Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. July 30 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: July 29 1945 at 7 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24, 1945, to July 29 1945 and that I last saw him alive on July 28, 1945

Immediate cause of death	DURATION
Cerebral thrombosis	2 wks.
Due to: Arterio-sclerosis	
Due to:	
Other conditions: Broncho-pneumonia, Pulmonary infection	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. S. Stauffer, M.D. M. D. or other

Address: Hagerstown, Md. Date signed: July 30, 1945

(M) ✓

(1)

(T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (d)

07340 34

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
525 South Potomac Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 525 South Potomac Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Anna M. Sager

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife John W. Sager
6.(c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) September 10, 1881

8. AGE: Years	Months	Days	If less than one day
63	10	8	....hrs. ....min.

9. Birthplace Harper Ferry, W.Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Benj. F. Medlar
13. Birthplace Harpers Ferry, W.Va.

MOTHER
14. Maiden name Fanny Hardie
15. Birthplace Harpers Ferry, W.Va.

16. Informant John W. Sager
Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-20-45 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons
Address Hagerstown, Maryland

19. July 19 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1945 19.... at 12 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11/8/43 19.... to July 18 19 45
and that I last saw her alive on July 17 19 45

	DURATION
Immediate cause of death: Hypostatic pneumonia	1 day
Due to: Chronic myocarditis with congestive failure	Indef
Other conditions: Chronic nephritis with hypertension	Indef.
Other conditions: Diabetes Mellitus	Indef.
Chronic cholecystitis	Indef
Cerebral Hemorrhage (Include pregnancy within 3 months of death)	2 weeks

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. B. Chrisler M. D. or other
Address 148 W. Washington St. Date signed 7/18/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

33

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 17341 302

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

602 North Potomac Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 602 North Potomac Street

(If rural, give LOCATION)

2.(a) If veteran, name war: World war #1

3. (a) FULL NAME: George W. Seaman

3. (b) Social Security Number: 216-14-6899

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Doris P. Seaman

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): November 27, 1895

8. AGE: Years	Months	Days	If less than one day
49	7	20	....hrs. ....min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Retired carpenter

11. Industry or business

FATHER 12. Name: John H. Seaman

FATHER 13. Birthplace: Sharpsburg, Maryland

MOTHER 14. Maiden name: Virginia S. Seibert

MOTHER 15. Birthplace: Clearspring, Maryland

16. Informant: Mrs. George W. Seaman

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-20-45 (month) (day) (year)

Cemetery or crematory: National Cemetery

Location: Sharpsburg, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. July 19 1945 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/17/45, 19..., at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/17/45, 19..., to 7/17/45, 19...

and that I last saw h... alive on 7/17/45, 19...

Immediate cause of death	DURATION
(a) Coronary Thrombosis	6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: ... Date signed 7/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

07342 ★ Reg. Dist. No. 302

6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 49 years
Hospital, institution, or street address where death occurred:
401 Liberty St.
How long in hospital or institution? 49 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 401 Liberty St.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: Nellie M. Sellers

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Ralph E. Sellers
6.(c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): August 17, 1895

8. AGE:	Years	Months	Days	If less than one day
	49	10	14	...hrs. ...min.

9. Birthplace: Hagerstown Washington Md.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: home
FATHER 12. Name: Kelly Garlock
13. Birthplace: Hagerstown, Md
MOTHER 14. Maiden name: Catherine Strock
15. Birthplace: Hagerstown, Md.
16. Informant: Ralph E. Sellers
Address: Hagerstown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Md.
18. Funeral director: Scott F. Minnich & Son
Address: Hagerstown, Md.
19. July 3. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1945 at 2:15p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to July 1. 1945 and that I last saw h...ed alive on July 1. 1945

Immediate cause of death	DURATION
Hypertension Cerebrovascular renal disease.	5 years.
Due to	
Due to	
Other conditions Arterial thrombosis right leg. (Include pregnancy within 3 months of death)	1 Month

Major findings of operations: No operation Date of op.
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. A. Beee M. D. or other
Address: Hagerstown Md. Date signed 7/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

CERTIFICATE OF DEATH

07343

Reg. Dist. No. 3-

1. PLACE OF DEATH:
County Washington
City or town Hancock
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No. Blue Hill
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Aydrey Lorraine E. Shives

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 10 1937

8. AGE: Years	Months	Days	If less than one day
7	8	21	..... hrs. ..... min.

9. Birthplace Hancock, Md. (Town, county, and state)
10. Usual occupation Student
11. Industry or business

FATHER
12. Name Earnest Shives
13. Birthplace Washington Co.

MOTHER
14. Maiden name Mary Souders
15. Birthplace Fulton Co. Pa.

16. Informant Mrs. Mary Shives
Address Hancock, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 3 1945 (month) (day) (year)
Cemetery or crematory Rehobeth Cemetery
Location Near Hancock, Fulton Co. Pa.

18. Funeral director Snyder-Rowland
Address Hancock, Md.

19. July 31 1945 (Date rec'd by registrar) J. A. Heller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1945 at 12:30 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 1945 to July 31 1945 and that I last saw h[illegible] alive on July 20 1945

Immediate cause of death	DURATION
Acute Dilatation Heart	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE L. M. Shaffer M.D. M. D. or other
Address Hancock Md. Date signed 7/31/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07344

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Rural, Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, Institution, or street address where death occurred: Paramount, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rural, Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hagerstown, Route #4
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Jennie A. Sigler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Harry F. Sigler
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 11, 1881

8. AGE: Years	Months	Days	If less than one day
63	7	22	..... hrs. ..... min.

9. Birthplace: Sabillasville, Fred. Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: David Pryor
13. Birthplace: Not Known

MOTHER
14. Maiden name: Laura N. Willard
15. Birthplace: Not Known

18. Informant: Mrs. Paul Hoover
Address: Paramount, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-6-45 (month) (day) (year)
Cemetery or crematory: Green Hill Cemetery
Location: Waynesboro, Pa.

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. July 5. 1945 Chas. H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3, 1945, at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2, 1945, to July 3, 1945, and that I last saw h[illegible] alive on July 3, 1945.

	DURATION
Immediate cause of death: Coronary Occlusion	1/2 hour
Due to: Hyperthyroidism	6 months
Due to: Chronic Myocarditis	5 months
Other conditions: Hypertension	5 months

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. —
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) ..... (County) ..... (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. Howard Yeager, M. D. or other
Address: Hagerstown, Md. Date signed: July 3, 1945

(M) MARGIN RESERVED FOR BINDING (T) (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

no 5

67345

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 305

1. PLACE OF DEATH:
County: Washington County
City or town: Bredthedsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12-1-41
Hospital, Institution, or street address where death occurred:
Md. state Reformatory for Males
How long in hospital or institution? 9 2/12 yrs 7 Mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Mont Co
City or town: Beallsville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Richard Randolph Simms

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	

6.(b) Name of husband or wife
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 12-26-21

8. AGE: Years	Months	Days	If less than one day
23	7	2	..... hrs. ..... min.

9. Birthplace: Poolesville Md Mont. Co. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: John I Simms
13. Birthplace: Poolesville Md
MOTHER 14. Maiden name: Marion A. Hall
15. Birthplace: Poolesville Md
16. Informant: Marion Simms
Address: Beallsville md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 1 1945 (month) (day) (year)
Cemetery or crematory: Poolesville
Location: Poolesville Md
18. Funeral director: Clarence H. Davis
Address: Poolesville md
19. July 29 1945 (Date rec'd by registrar) John N. Best Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1945 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 14 1942, to July 28 1945 and that I last saw him alive on July 28-45

Immediate cause of death	DURATION
Tuberculosis	
Pulmonary Tuberculosis	3 yrs
Due to	
Due to	
Other conditions 0	

(Include pregnancy within 3 months of death)

Major findings of operations: 0
Date of op.
Autopsy results: 0
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Robert P. Conrad M.D.
M. D. or other
Address: Hagerstown, Md Date signed: 7-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-9

CERTIFICATE OF DEATH ★

07346

24

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

Washington County Home

How long in hospital or institution? 7 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Washington County Home

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Sites

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 7, 1897

8. AGE: Years	Months	Days	If less than one day
48	5	7	hrs. min.

9. Birthplace: Hagerstown, Wash. Co. Md. (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business:

FATHER

12. Name: Charles A. Sites

13. Birthplace: Williamsport, Maryland

MOTHER

14. Maiden name: Fanny B. Cottrill

15. Birthplace: Williamsport, Maryland

16. Informant: Lesher Sites

Address: Harrisburg, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-16-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. July 16 19 45 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14th 19 45 at 7 34 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 19 45, to July 14 19 45 and that I last saw h... alive on Jan 11 19 45

Immediate cause of death	DURATION
Lues - Tertiary	3 yrs.
Due to: Rodent Ulcer Buttocks	5 Mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. V. Boerhaave M. D. or other

Address: Hagerstown Md Date signed: 7/14/45

47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

07347

Reg. Dist. No. 30 2

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 23 Brantonalley
(If rural, give LOCATION)
2.(a) If veteran, name war NONE

3. (a) FULL NAME Unnamed Child of Max Snowden

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Premature

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Premature

8. AGE: Years | Months | Days | If less than one day: 3 hrs. 40 min.

9. Birthplace Hagerstown Wash. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER
12. Name Max Snowden
13. Birthplace Hagerstown Md.

MOTHER
14. Maiden name Alice Monroe
15. Birthplace Sheperdstown W. Va.

16. Informant Max. Snowden
Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 1,1945 (month) (day) (year)
Cemetery or crematory Rose Hill
Location Hagerstown Md.

18. Funeral director Scott F. Minnich & Son
Address Hagerstown Md.

19. July 31 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1945 at 5:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2:05 A 7-31 1945 to 5:45 A 7-31 1945
and that I last saw h alive on 1945

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Curtiss Mayfield, Jr. M.D. M. D. or other
Address 242 Potomac St. Date signed 7-31-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ 17348

Reg. Dist. No. 303

1. PLACE OF DEATH:
County: Washington
City or town: Big Pool Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
Potomac River near Ernstville
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Big Pool, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route 40
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Betty Ruth Spade

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23, 1932

8. AGE: Years 13 | Months 2 | Days 15 | If less than one day: hrs. min.

9. Birthplace: Fulton County, Pa.
(Town, county, and state)

10. Usual occupation: School Student

11. Industry or business:

FATHER
12. Name: Earl Spade
13. Birthplace: Emmaville, Pa.

MOTHER
14. Maiden name: Ina Clark
15. Birthplace: Bedford County, Pa.

16. Informant: Earl Spade
Address: Big Pool, Md. R F D

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 11, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Clear Spring, Md.

18. Funeral director: Snyder-Rowland Funeral Home
Address: Clear Spring, Md.

19. July 11 19 45 Joseph W. Murray Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1945 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death: Suffocation by
Due to: drowning
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

DURATION

Major findings of operation: No
Date of op.:
Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: July 8-45
Where did injury occur? Big Pool (City or town) Washington (County) Md. (State)
Injured at home, farm, industry, public place (where?): Potomac river
Means of injury: Wading and stepped into deep water

23. SIGNATURE: Stokes & Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.
M. D. or Coroner
Address: Hagerstown, Md. Date signed: July 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★

#7343

Reg. Dist. No. 303

1. PLACE OF DEATH:

County: Washington

City or town: Big Pool Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:
Potomac River near Ernstville

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Big Pool, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 40
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Raymond Charles Spade

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 5, 1930

8. AGE:

Years	Months	Days	If less than one day
15	1	3	..... hrs. ..... min.

9. Birthplace: Bedford County, Pa.
(Town, county, and state)

10. Usual occupation: School Student

11. Industry or business

FATHER
12. Name: Earl Spade
13. Birthplace: Emmaville, Pa.

MOTHER
14. Maiden name: Ina Clark
15. Birthplace: Bedford County, Pa.

16. Informant: Earl Spade
Address: Big Pool, Md. R F D

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Clear Spring, Md.

18. Funeral director: Snyder-Rowland Funeral Home

Address: Clear Spring, Md.

19. July 11 1945 (Date received by registrar) Joseph W. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1945 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
suffocation by	
Due to drowning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NO

Date of op.

Autopsy results: NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of July 8. 45
Where did injury occur? Big Pool (City or town) Washington (County) Md. (State)
Injured at home, farm, industry, public place (where?) Potomac river
Means of injury: Wading & stepped into deep water Injured at work?

DEPUTY MEDICAL EXAM.
23. SIGNATURE: Hokes & Wells WASH. CO., MD.
M. D. or ...
Address: Hagerstown, Md. Date signed July 9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (730)

CERTIFICATE OF DEATH

07350

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 87 years
Hospital, institution, or street address where death occurred:
138 East Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 138 East Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME: Samuel C. Spielman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ida Spielman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 5, 1857

8. AGE: Years	Months	Days	If less than one day
87	7	26	..... hrs. ..... min.

9. Birthplace: Fiddlersburg Wash. Md.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: School Teacher
FATHER 12. Name: Hezehiah Spielman
13. Birthplace: Fiddlersburg Md.
MOTHER 14. Maiden name: Elizebeth Waltemyer
15. Birthplace: Hagerstown Md.
16. Informant: Miss Mary Spielman
Address: Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 2, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown Md.
18. Funeral director: Scott F. Minnich & Son
Address: Hagerstown Md.
19. Aug. 2, 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1945 at 7:15p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-14-41 19.. to 7-31-45 19.. and that I last saw him alive on 7-26-45 19..

Immediate cause of death	DURATION
Chr. Myocarditis	1 yr
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H W Gitt M. D. or other
Address Hagerstown Md. Date signed 8/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

07351 31

★ Reg. Dist. No. 30 2

1. PLACE OF DEATH:
County: Washington
City or town: (within corporate limits) Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, institution, or street address where death occurred:
801 Oak Hill Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: (within corporate limits) Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 801 Oak Hill Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American War

3.(a) FULL NAME: Clarence E. Steele

3.(b) Social Security Number: 217-10-3045

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maude A. Steele
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 3, 1875

8. AGE: Years	Months	Days	If less than one day
69	7	14	hrs. min.

9. Birthplace: Riceville, Iowa (Town, county, and state)
10. Usual occupation: Y. M. C. A. Secretary Retired
11. Industry or business

FATHER
12. Name: Joseph Steele
13. Birthplace: Iowa

MOTHER
14. Maiden name: Sarah Simmons
15. Birthplace: Iowa

16. Informant: Mrs. Maude A. Steele
Address: 801 Oak Hill Ave. - Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 20, 1945 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown, Md.
18. Funeral director: Fred W. Kraas.
Address: Hagerstown Md.

19. July 19 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1945, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 1945 to July 17 1945 and that I last saw h... alive on July 17 1945

Immediate cause of death	DURATION
Due to: Coronary Occlusion	1934.
Due to: Coronary Occlusion	6.1945
Due to: Congestive Heart Failure	3 hrs
Other conditions: Pulmonary Edema	4 days

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Ernest F. Cook M.D. M. D. or other
Address: Hagerstown Md. Date signed: 7/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-A)

CERTIFICATE OF DEATH

07352 27

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown – 31 E. Irvin Ave

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? –

Hospital, Institution, or street address where death occurred: –

How long in hospital or institution? –

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 31 E. Irvin ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emmert F Toms

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Daisy May

7. Birth date of deceased (mo., day, yr.) Sept 5th 1874 — 6.(c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day
70	10	11	..... hrs. ..... min.

9. Birthplace Frederick Co. Md. (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name Joseph Toms

FATHER 13. Birthplace Frederick Co. Md

MOTHER 14. Maiden name Ann Schindel

MOTHER 15. Birthplace Washington Co. Md.

16. Informant Kathryn R. Toms

Address 31 E. Irvin Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/18/45 (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director L. F. Reecher

Address Funkstown, Md.

19. July 17 19 45 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945 19..... at 2:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 19 45 to July 16/45 19.....

and that I last saw him alive on July 16/45 19.....

Immediate cause of death	DURATION
Chr. myocarditis	4 YRS
Due to vascular hypertension	5 yrs
Due to Coronary arteriosclerosis	3 yrs
Other conditions uremia	3 d.

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Roland Wells M.D. M. D. or

Address Hagerstown, Md. Date signed July 18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

22

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45-d

07353

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred: 864 Mulberry ave

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 864 Mulberry ave.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME William R. Winders

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Emma B. Winders

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 17 - 1857

8. AGE:

Years	Months	Days	If less than one day
88	2	20	..... hrs. ..... min.

9. Birthplace Beaverdale Wash. Co. Md.

(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business Dairy Farm

FATHER

12. Name Levy R. Winders

13. Birthplace Wash. Co. Md.

MOTHER

14. Maiden name Mary Mayslles

15. Birthplace Wash. Co. Md.

16. Informant Mrs. Emma B. Winders

Address 864 Mulberry Ave. Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetary

Location Hagerstown Md.

18. Funeral director Levy D. Bast & Sons

Address Boonsboro Md

19. July 12, 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1945, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 17, 1945 to July 7, 1945 and that I last saw him alive on July 5, 1945

	DURATION
Immediate cause of death Arteriosclerosis	10 yr
Due to Carcinoma Lower jaw and pharynx	11 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations No

Date of op. No

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X Date of X

Where did injury occur? X (City or town) X (County) X (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. Howard Yeager M. D. or other

Address Hagerstown, Md Date signed July 7, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

No 1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 17354

Reg. Diat. No. 305

1. PLACE OF DEATH

County: Washington

City or town: Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days.

Hospital, institution, or street address where death occurred: N. Main St.

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: near Cearfoss - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Hagerstown, Md. R. 2

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Esther Viola Wolfe

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Frank E. Wolfe.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December - 3 - 1903

8. AGE:

Years	Months	Days	If less than one day
41	7	1	..... hrs. ..... min.

9. Birthplace: near Boonsboro Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER

12. Name: Clayton Smith

13. Birthplace: near Boonsboro Wash. Co. Md.

MOTHER

14. Maiden name: Jannie Smith

15. Birthplace: Samples Manor Wash. Co. Md.

16. Informant: Frank E. Wolfe

Address: Hagerstown Md. R. 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 7. 1945 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetary

Location: Boonsboro Md.

18. Funeral director: Wm. J. Bast & Sons

Address: Boonsboro Md.

19. July 6. 1945 (Date rec'd by registrar) John H. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4 1945, at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1945, to July 1945

and that I last saw h alive on July 1945

	DURATION
Immediate cause of death: Carcinoma of Cervix	
Due to: Uremia and General Edema	14 days
Due to: Abdominal Viscera	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the csuse to which death should be charged statistically.

22. VIOLENCE: If death waa due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Williamsport Md. Date signed 7/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. wells 41

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B1-a)

CERTIFICATE OF DEATH

17355

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Weeks

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 11 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 327 North Mulberry St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Charles Vernon Yessler

3.(b) Social Security Number: 214-09-8469

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Hart

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Junee 5 1877

8. AGE: Years	Months	Days	If less than one day
68	1	22	....hrs. ....min.

9. Birthplace: Chewsville wash. Co. Md. (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Shoe Repair Shop

FATHER 12. Name: Samuel Yessler

FATHER 13. Birthplace: Chewsville Md.

MOTHER 14. Maiden name: Elizabeth Bowers

MOTHER 15. Birthplace: Chewsville Md.

16. Informant: Mrs. Anna H. Yessler

Address: Hagesrtwon Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/29/45 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Chewsville Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. July 28, 1945 (Date rec'd by registrar) Clark H. Bowers Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH: July 27 1945, 19..., at 3.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 24 1941, to July 27 1945 and that I last saw him alive on July 27 1945

Immediate cause of death	DURATION
Chronic glomerular nephritis	6yr s
Due to: Chr. Myocarditis	5 yrs
Due to: Vascular hypertension	3 yrs
Due to: coronary occlusion	9mo
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: L. Richard Wells, M.D. M. D. number

Address: Hagerstown, Md. Date signed 7/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING